12 ASPECTS OF STAFF TRANSFORMATION

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There is a lot of talk about transforming our mental health system into a consumer-driven recovery-based system, but very little talk about transforming staff to work successfully in this new system. Recovery programs, to this point, tend to rely on creating small counter-cultures with dynamic leadership, staff that are different or want to change, and new non-professional and consumer staff. Transforming existing programs with existing staff will require a proactively guided process of staff transformation to succeed. This paper describes 12 aspects of staff transformation.

1. Looking Inward and Rebuilding the Passion: Recovery work requires staff to use all of themselves in passionate ways to help people. It cannot be done effectively in a detached, routinized way. Recovery staff tend to be happier, more full of life, and more actively engaged. To achieve this, staff has to look inwards to remember why our hearts brought them into this field in the first place. For many staff, our hearts have been buried under bureaucracy, paperwork, under-funding, frustrations, and burn out. Staff must be nurtured, encouraged to play and explore, to bring our lives into our work, and cherished for our individual gifts and hearts. Staff with hope, empowerment, responsibility, and meaning can help people with mental illnesses build hope, empowerment, responsibility, and meaning. Administrative leadership must effectively promote their staff before further transformation can occur.

2. Building Inspiration and Belief in Recovery: Staff spend the vast majority of our time and emotions on people who are doing poorly or in crisis. We neglect the stories of our own successes and our roles in supporting these successes. Staff need to be inspired by hearing people tell their stories of recovery, especially the stories of people we have worked with and also known in darker times. We also need to be familiarized with the extensive research documenting recovery and the concept of the "clinicians' illusion" that gets in the way of us believing in this research. Ongoing experiences of people achieving things we "know are impossible" are crucial.

3. Changing from Treating Illnesses to Helping People with Illnesses Have Better Lives: Recovery staff treat "people like people" not like cases of different illnesses. The pervasive culture of medicalization is reinforced by the infrastructure. Goal setting needs to reflect quality of life, not just symptom reduction. Quality of life outcomes need to be collected. Treatment must be life-based, not diagnosis-based. Assessments must describe a whole life, not an illness

with a psychosocial assessment on a back page. Progress notes need to reflect life goals, not just clinical goals. Team staff meetings need to discuss practical problems of life.

4. Moving from Caretaking to Empowering, Sharing Power and Control: Staff have generally adopted a caretaking role towards people with a mental illness. We act protectively, make decisions for them because of their impairments, even force them to do what we think is best for them at times. Recovery practice rejects those roles, although many staff and mentally ill people are comfortable with them. Analogously, to how parents must stop being caretakers for our children to become successful adults, staff must stop being caretakers for people we work with to recover. There are enormous issues around fear of risk taking, feelings of responsibility for the people we work with, and liability concerns that become involved as staff try to become more empowering. There may also be personal issues around power and control. Most staff feel most efficient and effective when we are in control and people are doing what we want them to. Especially when facing repeated failures, or crisis, frustration is likely to grow. We are likely to reject collaboration and want to take more power and control.

5. Gaining Comfort with Mentally Ill Co-Staff and Multiple Roles: Recovery requires breaking down the "us vs. them" walls. People with mental illnesses must be included as collaborators, co-workers, and even trainers. Working alongside mentally ill people as peers (not as segregated, second-rate staff) is probably the single most power stigma-reducing and transforming experience for staff. For people with mental illness to recover and attain meaningful roles beyond their illness roles, staff need to take on roles beyond our illness treatment roles. Programs can promote this transformation by creating activities like talent shows, cook-outs, neighborhood clean-ups, art shows, etc., where staff and mentally ill people interact in different roles.

6. Valuing the Subjective Experience: Staff have been taught to observe, collect and record objective information about people to make reliable diagnoses and rational treatment plans. Recovery plans are collaborative. To achieve this collaborative partnership, staff must appreciate not just what's wrong with a person, but how that person understands and experiences what's happening. Knowing what it would be like to be that person, what they're frightened off, what motivates them, what their hopes and dreams are, are all part of a subjective assessment. Charted assessments, "case conferences" (shouldn't these be "people conferences"?), team meetings, and supervision all should value subjective understandings.

7. Creating Therapeutic Relationships: Recovery work emphasizes therapeutic work more than symptom relief. Our present system relies on illness diagnosis, treatment planning, treatment prescription, and treatment compliance. Staff can be interchangeable, professionally distant, even strangers, so long as the diagnosis, plan and compliance is preserved. Recovery work relies on the same foundation as psychotherapy: (1) an ongoing trusting, collaborative, working relationship, (2)

a shared explanatory story of how the person got to this point, and (3) a shared plan of how to achieve the person's goals together. Staff need to gain, or regain, these skills. Program designs must prioritize relationships so staff can create relationships.

8. Lowering Emotional Walls and Becoming a Guiding Partner: People repeatedly tell us that we are the most helpful when we re personally involved, genuinely caring, and "real". Psychotherapeutic and medical practice traditions, ethical guidelines, risk management rules, and personal reluctance come together against lowering emotional walls. Staff needs lots of discussion and administrative support to change in spite of these strong contrary forces. To best support a person on their path of recovery, staff need to act not as detached experts giving them maps and directions, but to actually become involved, walking alongside them as guides, sharing the trip. Staff's emotional and physical fears of the people we work with need to be dealt with as well as to lower the walls.

9. Understanding the Process of Recovery: Staff are familiar with monitoring progress as a medical process. We follow how well illnesses are diagnosed, treated, symptoms relieved, and function regained. We alter our interventions and plans based on our assessment of this process. Recovery work monitors a very different process - the process of recovery. Analogously to the grief process hospice works with, the recovery process can be described by a series of 4 stages: (1) hope – believing something better is possible, (2) empowerment - believing in ourselves, (3) self-responsibility - taking actions to recover, and (4) attaining meaningful roles apart from the illness. Where hospice staff help people die with dignity, recovery staff help people live with dignity. Staff grow in their understanding of the recovery process and their skills in promoting recovery.

10. Becoming Involved in the Community: Recovery tries to help people attain meaningful roles in life. These roles will require them to be reintegrated into the community, to be welcomed and to be valued, to find their niches. Recovery cannot be achieved while people are segregated from their communities or protected in asylums. To support this, staff must work in the community. We can't be segregated from our communities or act solely as protectors in asylums. We need to be welcomed and valued and to find our niches. This is a substantial change for most staff and may trigger personal insecurities. Community development and anti-stigma work are important new programmatic and staff responsibilities.

11. Reaching Out to the Rejected: Recovery is being promoted, not just as a way of helping people who are doing well do even better, but also as a way of engaging with and helping people who do not fit well with the present system. Recovery programs have proven success with people with dual diagnoses, homeless people, jail diversion people, "non-compliant" people, people with severe socio-economic problems, and people lacking "insight". Each of these people has different serious obstacles to engagement and treatment, and staff often have serious prejudices

against them. A “counter-culture of acceptance” needs to be created to work with them. This often requires both an attitudinal change in staff and training in specialized skill sets. The system transformation will not be considered a success if we continue to reject these people in need.

12. Living Recovery Values: “Do as I say, not as I do” is never a good practice. When the walls and barriers are reduced and emotional relationships enhanced in a good recovery program, it’s even harder to hide. Staff must live the values of recovery and be actively growing ourselves if we expect to be effective recovery workers. In recovery, the same rules and values apply to all of us.

By describing these 12 aspects of staff transformation I have tried to create both a proactive curriculum for staff transformation, and a guide for recovery oriented leaders to use in program design, supervision, and staff support.